

### **Introductions/Approval of Minutes**

Chairperson Fitzgerald called the meeting to order at 1:35PM. Present were Fitzgerald, Aschenbrenner, Gessow, Branstad, Laue, Voss, Dierenfeld (Griffin) Brewer, Teeling, Newton. Governor Vilsack participated briefly by telephone.

Laue made a motion to approve the September 17, 2008 minutes. Aschenbrenner seconded the motion. The minutes were unanimously approved.

### **Review of the Lewin Report**

Discussion of the Lewin report was deferred until the next meeting due to the absence of certain council members. The change in the agenda was agreed upon by the members.

### **Review of Reports and Data from HIPIowa**

Cecil Bykerk and Pat Carmody were present to discuss handouts that included the association's operations report and financial report from August as well information about the pricing of the association's policies. Chapter 514E of the Iowa Code sets forth the limits based on the average market rates (AMR). Rates are currently set one time per year and are set at 150% AMR. The handout displayed what premiums would look like if set at some level less than 150% [Plans B, D and G at shown 130%, 120% and 110% of AMR]. The inquiry initiated by an HIPIowa board member was based on the assertion that if the association was able to lower the rates, the cost would be reduced, thereby, increasing the number of participants and reducing the number of uninsured. Bykerk explained if rates are set at a lower level then greater losses and larger assessments against the insurance companies. If rates are set too low, then the plan will actually compete with the market place. Questions followed about premium taxes and the premium tax offset which is spread over five years. The distribution of the premium tax offset is related to the relative premium dollar written by the insurer. Voss shared that last year insurers generated gross premium taxes in the sum of \$130,000,000 that goes directly to the general fund. The financial report reflects the 2008 and 2007 assessments of \$10,000,000 and \$18,000,000 respectively. Bykerk explained that in 2005 the association began with a 100 or so people and is now up to approximately 3,000 people insured through HIPIowa. Bykerk also explained that the association had received some federal grant money in the past. Bykerk was asked by Laue to opine on the trend of losses. Typically they go up and lose money on everyone because of the population insured. In response to the question from Branstad as to

how much losing per person, Bykerk estimated the sum of approximately \$5,000 per person. The advantage to the state of Iowa and to the individuals insured is the revenue that they contribute via payment of premiums; rather than being uninsured and being dumped into the uncompensated care category these individuals did pay \$10,000,000 towards their care. Question from Gessow arose as to the amounts paid to providers. Bykerk stated that the association uses the Midlands Network. Aschenbrenner suspected that the amount paid by the network to providers might be 50% higher than amounts paid by Medicare or Medicaid but 20% lower than what Wellmark might pay. The comment was made that if the legislature paid for the cost of covering individuals upfront versus offering the premium tax offset to insurers who currently provide the coverage upfront, an appropriation would be required. The assessment is an allowable expense for inclusion in an insurer's premium calculation; therefore, the cost of an assessment is either passed on to taxpayers via the premium tax offset or through their premium payments noting that the costs are only passed on to the insured plans, self-insured plans not included. Carmody mentioned Nebraska's process where the assessment goes to the department, the department determines the amount of the plan's loss and the remainder goes to the general fund. There are some states that appropriate money for their high risk plan.

### **Individual Subgroups Updates and Discussion**

*What Children Subgroup.* Governor Vilsack joined the meeting and due to his limited time availability Fitzgerald interrupted the HIPIowa portion of the meeting to permit Vilsack to share with the advisory council the results of the subgroup meeting held on September 30<sup>th</sup>. Fitzgerald distributed handouts. Vilsack urged the council to look at defining all children as all children as it is in the best interests of the state to do so. Sickness, disease and illness know no boundaries and it does not matter how long the children have been in this country. Also, it is an expense saver to the state because these individuals utilize emergency services more frequently than they would if they had insurance. Insuring all children allows the state to redirect resources and prevent the transfer of charity care. Other states have defined all children to include undocumented kids. Aschenbrenner remarked that failing to extend benefits to legal immigrant children barred for 5 years to be unconscionable. The map distributed noted that the states of WA, IL NY, MA and some counties in CA cover all children including undocumented. The states in blue just cover documented children and use state only dollars. States listed at the bottom cover illegal immigrant children also. Discussion followed that we could encounter political opposition by covering undocumented children which might jeopardize the whole package. Vilsack stated that the children did not have a role in making the decision to arrive in Iowa, and we want to protect our children from whatever diseases made preventable through vaccinations. Voss asked about numbers of undocumented children. Fitzgerald responded that these are really elusive numbers but

her office has a rough estimate between 6,000-10,000. Gessow thinks it would not work to cover the children without covering their illegal parents due to the fear that goes along with coming forward at a health care facility. Branstad shared his daughter's experience while teaching in CA where child had a head injury which needed stitches but was unable to convince the family to seek coverage. The offer of coverage to all undocumented children is different from whether medical attention is actually sought. Fitzgerald had queried other advocates about any increase in numbers and the feedback indicated that no spikes in coverage or enrollment had been seen when coverage was extended to all children. Fitzgerald then sought input from the council as to other avenues of research the subgroup might pursue. Teeling shared that he did not like the idea of covering illegal immigrants, doing so encourages criminal behavior and the group he represents would be opposed to covering illegal immigrants. Gessow recalled a concept in constitutional law where the child could not be charged with the crimes of the adult. Laue opined that it makes sense to cover all children because health care professionals probably do not want to sort out who is legal or illegal and for the health of all children in general. Dierenfeld suggested checking with the Department of Education as to any numbers. Karla Fultz McHenry of the Iowa Medical Society addressed the council and shared that some of their members found, especially in large Latino communities, that the medical home concept or continuity of care cannot be achieved if the mother must take one child to the free health clinic because of the undocumented status, she will take them all to the free clinic despite the ability of the one child born in the United States to qualify for health care perhaps through hawk-i. Gessow asked about the ethics of the profession when illegal persons seek treatment and perhaps learning through IDPH and the professional boards whether an ethical practice exists. The free clinics, part of the safety net, do not inquire as to immigration status in order to provide treatment. Children receive mostly well child care and vaccinations at the free clinics, not emergent care. In addition to offering to find out more information about the free clinics for the council, Branstad wanted the subgroup to find out what California counties are covered and what their experience was regarding implementing coverage for all children. Laue wanted to know what plans are available and exactly what they cover. When asked, Fitzgerald remarked that no state really covers all children but some states are better at covering immigrant children than others. The states closest to covering all children are: IL, WA, PA, MA and RI.

The council returned to the **Review of Reports and Data from HIPlowa**

Fitzgerald asked whether every state had a high risk pool and the number of states with high risk pools. Bykerk responded that not every state had a high risk pool but technically there were 36 states with such pools. When asked how Iowa compared to other states and the level of AMR, Bykerk guessed that the majority of states set the premium level at 130% or 135% of AMR. Very few were over 150% AMR and Iowa is

probably on the high end of the spectrum at 150% AMR. Branstad suggested that Iowa's AMR compared to other states is probably lower compared to other states due to lower health insurance premiums in general. Bykerk then referred to HIPIowa's monthly operation report noting the upward trajectory of enrollment over the years. Bykerk noted a leveling off and a slight decline in enrollment over the past 6 months but was not certain why the change in enrollment was occurring. Bykerk explained when asked how many people might be eligible for the HIPIowa plans that 11,000 people were in basic and standard plans when the changes were made in 2005. There was a reasonable probability that numbers HIPIowa's numbers reach up to 10,000 due to the numbers of persons with basic and standard policies. Five to six thousand still have basic and standard policies and they are eligible to come over to HIPIowa at any time. The most popular HIPIowa plan is the one with \$2,500 deductible. Bykerk shared that the typical duration for people remaining in the pool is 3 years. Bykerk shared an experience during his employment with Mutual of Omaha about the inertia people exhibit in moving from one plan to another even if it might save in premium costs. A minister had an annual premium of \$42,000. When contacted about increasing the deductible and that a higher deductible could reduce the premium to the \$10,000 to \$15,000 range, the minister declined to make the change because the church paid the premium but he paid the deductible.

### **Individual Subgroups Updates and Discussion**

*Benefit Review Subgroup.* Tom Newton, Chair. Paula Dierenfeld provided a memo prepared by Janet Griffin summarizing their meeting on September 29<sup>th</sup>. The subgroup began its discussion looking at a standard package design and compared benefits of programs currently available (e.g. Medicaid, hawk-i, and state of Iowa benefit plans). The subgroup decided that the hawk-i program served as good starting point and continued the discussion as to what additional benefits should be included. The subgroup proceeded to discuss costs and would like DHS to look at the package being developed as to hawk-i like benefits, the additional benefits that might be included and their associated costs. The subgroup discussed the age cutoff for coverage and concluded to coverage up to age 19 was appropriate as it is consistent with the age utilized by hawk-i. Next the subgroup discussed choices of plans noting hawk-i currently has managed care available to children are such plans exist. The standard plan developed should have similar options under managed care. Also, hawk-i should be considered creditable coverage as children move between plans. The subgroup also discussed inclusion of plans not available under typical insurance like vision or dental. The standard benefit plan would be available to all children. The subgroup did not discuss copayments or deductibles at this time. Council members discussed what additional information should be gathered by the subgroup including a cost analysis of

standard benefits as well as the cost of specific additional benefits; identification of any benefits which might be questionable or for which the group might be criticized for including or failing to include; premiums and per member per cost numbers; and a side-by-side comparison of the proposed benefit package and HF 2539. Laue noted that some groups have not yet met and that some other things might come up that have bearing on the benefit package and who is eligible.

*Adults Subgroup.* Teeling distributed and reviewed minutes from the subgroup's discussion on September 17<sup>th</sup>. Discussion followed about adults and the meeting schedule of the subgroups. Gessow remarked that ten to twelve states have waivers that allow coverage of low income individuals age 20 to 64. The subgroup will try to meet after the meeting on October 15<sup>th</sup>. The subgroup will gather information about what other states doing. Teeling announced that Voss would join this subgroup.

### **Planning to move forward with children's coverage plan/Wrap up/Adjourn**

Fitzgerald initiated discussion about the small groups meeting during the scheduled advisory council meetings, noting that some subgroups have yet to meet. Aschenbrenner sought confirmation from the council as to a prior discussion about bringing issues to a final resolution whenever possible. Discussion followed that some issues will need to be addressed by the entire group as a whole, but it would expedite the process with small groups doing the research and bringing information to the council. An e-mail reminding council members of their subgroup assignments will be sent following this meeting.

Aschenbrenner asked the council to ponder the issue of whether coverage should be mandatory or voluntary as well as what can be done to motivate parents to more actively provide insurance for children especially when the resources exist and the parents opt not to do so. Gessow referred to Vilsack's analogy to public education and how everyone pays for it. Gessow urged the council to think of mandates outside the health insurance area such as FICA, mortgage insurance, or workers compensation. Laue believes that health insurance must be affordable and should be made as attractive as possible before considering a mandate. Dierenfeld offered that perhaps there are incentives to offer parents so that they will obtain coverage. Fitzgerald expressed her opposition to a mandate when the matter first arose in the legislature as it failed to open up all avenues for coverage for parents and enforcement of a mandate was unclear. Branstad referred to Iowa's financial responsibility requirements of automobile insurance noting that Iowa had a higher percentage of insured than those states that mandated coverage. Branstad questioned whether the state wanted to

occupy the role of tracking down parents if they fail to provide coverage while remarking that sometime the cost of enforcement outweighs the benefits.

The council will review the Lewin report at the next meeting.

Meeting adjourned at 4:19PM.